

## Society Proceedings

NEW YORK NEUROLOGICAL SOCIETY.

October 6, 1903.

The President, Dr. Pearce Bailey, in the Chair.

*Partial Paralysis of the Platysma Myoides following Typhoid.*—Dr. Edwin G. Zabriskie presented a girl of seventeen, a cigarette-maker by trade. Following an attack of typhoid fever five years ago a sinus formed in connection with the lower jaw on the left side. On coming under observation recently it was found that there was paralysis of the left platysma myoides, and that this muscle failed to respond to electrical stimulation.

*Extirpation of Gasserian Ganglion for Neuralgia.*—Dr. William Hirsch presented a woman who had been operated upon one year ago for the relief of trigeminal neuralgia by the removal of the Gasserian ganglion. Microscopical examination showed that the ganglion had been completely extirpated. The neuralgia had been completely relieved. There was no analgesia anywhere. Remak claimed that one result of paralysis of the trigeminal nerve was a pushing of the lower jaw over towards the affected side, associated with partial subluxation. This patient showed only a slight deviation. In this woman the perception of a sweet taste was somewhat uncertain, that for sour was lost, and the taste for bitter was perverted. The electrical reaction of the muscles on the affected side was perfectly normal, but the effect of the current as regards taste had not been noted.

*Congenital Multiple Angiomata.*—Dr. M. Abrahamson presented a boy of fifteen years, born in Russia after a very prolonged labor. He was cyanotic at birth, and was resuscitated with difficulty. When two months old the mother first noticed a small mass behind the left ear; another appeared on the left side of the neck when two years old, after a fall. Since then new ones had appeared. Epistaxis had been frequent, but there had been no hemorrhages from the other mucous membranes. There were a number of these swellings, or angiomata, notably in the tongue and lip. There was an angioma in the retina of the right eye. There were apparently no angiomata in the liver and spleen. This boy showed both of Virchow's types—cavernous and fissural. The course of the disease in this case was not in accordance with any of the theories that had been advanced to explain such cases.

*Hysterical Gait.*—Dr. William M. Leszynsky presented a boy of eleven years who had been born at full term by forceps without suspended animation. He had never had convulsions. He seemed perfectly well up to nine months ago, when he began to bend forward when walking. When first seen, on March 9, 1903, his general health was found to be good. The knee-jerks were unobtainable, and the limbs became rigid in various positions. No evidence of organic nervous disease was discovered, and a few days later the knee-jerks were elicited. He was discharged after 16 days, walking perfectly well, but he was re-admitted to hospital in July in a condition similar to the original one. The speaker believed at first that the attitude was imitated, and that subsequently it became a habit. Although the boy walked in a doubled-up position with the head almost touching the floor, he could hang upon a horizontal bar without special difficulty. When in bed he lay like other children. There were no objective sensory

disturbances of hysteria. For want of a better name it was called a case of hysteria. This habit had persisted, and remained even when he was not observed. There was, of course, exaggeration and a certain element of simulation.

*The Movements of Superior Intercostal Muscles in Hemiplegia, and the New Hemiplegic Symptom.*—Dr. L. Pierce Clark presented this paper. He said that Gowers expressed the generally accepted opinion regarding the respiratory movements in hemiplegics when he said that in ordinary respiration the two sides of the thorax moved equally, but that in extraordinary respiration there was often less expansion on the paralyzed side. In 1895 Hughlings Jackson stated that in hemiplegics the superior intercostal movements were greater on the paralyzed side during ordinary or automatic respiration, whereas in forced respiration the movement was greater on the sound side. The speaker said that he had examined with regard to this point 161 cases of hemiplegia, with the result that this sign was found to be uniformly present. In destructive lesions of the internal capsule causing hemiplegia, the cortical inhibitory control over the medullary respiratory center of the paralyzed side was largely destroyed, and, accordingly, the inhibited medullary center acts excessively in automatic respiration. The experiments of W. G. Spencer demonstrated the presence of an inhibitory center situated just outside of the olfactory tract, anterior to its junction with the temporo-sphenoidal lobe, and of an acceleration center apparently located in the posterior portion of the sensory-motor area of the cortex. The location of the inhibitory center would lead one to expect it to be damaged in vascular lesions, especially of the middle cerebral, affecting the integrity of the capsular fibers. The fact that the superior intercostals of the paralyzed side were innervated through cerebral fibers ending on spinal centers in the anterior horns of the cord, and the more or less marked damage of the same would account for the general motor loss of volitional acts on the hemiplegic side. The respiratory center could be demonstrated in all muscles bilaterally susceptible of both automatic and volitional movements.

*The Advisability of Supplementing the Words Degeneration and Degenerate by Deviation and Deviate.*—Dr. G. L. Walton, of Boston, presented a paper with this title. The definitions given by a number of well-known writers were cited to show that a degenerate was one exhibiting certain deviations from the normal type. The words "deviation" and "deviate," therefore, seemed to him to be more accurate, and less objectionable because independent of all theories. Referring to the hereditary aspects of the question, attention was called to the tendency of similar parents to produce inferior degenerates and of dissimilar parents to produce beings superior to their immediate ancestors. The term "degenerate" he would limit, so far as possible, to the lowest grades of constitutional defect, and avoid altogether the anomalous term "superior degenerate."

Dr. Hirsch said that about ten years ago he had himself pointed out the apparent misuse of the term degenerate. The definition which he had given at the time of degeneration was, "a mild development of the psychical organ." The term, superior degenerate, was not originally applied in the way in which it was referred to in the paper, i.e., a degeneration of a less degree, but rather that the higher faculties of certain individuals were degenerated. The word "deviation" unfortunately was not one which could be used internationally, and this, in itself, constituted a serious objection to its adoption, although there could be no doubt about the term being superior to degeneration.

Dr. C. L. Dana said that he was very much in sympathy with the purpose of this paper, and that his own views regarding degeneration

did not differ very much from those of the author. He understood that Dr. Walton wished to continue the use of the term degeneration in connection with somatic changes. About eight years ago, in an address before the Academy of Medicine, the speaker said he had defined a degenerate as "one who differed from the average standard of the family from which he sprung," and suggested that there were two classes of degenerates to whom the term could be applied without any implied opprobrium. One of these was the class spoken of in the paper as the "superior degenerate." He thought the term "variation" could be very properly applied. He was of the opinion that in the superior degenerates and in the inferior degenerates, and in the imbeciles, and even in the higher types there was a degenerative tendency in the germoplasm, and that the family was very apt to die out.

Dr. B. Sachs thought that if degeneration were too severe a term, deviation was too mild a term, for it could not be looked upon as representing anything morbid. After all, the only objection to the term degeneration, was in its application to the so-called superior degenerate, and the vast majority of the persons to whom the term degenerate had been applied showed a distinctly downward tendency.

Dr. Joseph Collins said that the substitution of terms suggested by the author of the paper did not seem to him a wise move, but an effort to incorporate those terms into medical literature to express certain conditions often included under the terms degeneration and degenerate, should be encouraged. Because some of the indecent newspapers saw fit to use the term degeneracy merely as a synonym for moral profligacy, and particularly sexual perversion, was no reason for the scientific world to feel called upon to change this term. Even in scientific circles it seemed to him that the term degenerate was used altogether too frequently. He believed that the usual tendency in both superior and inferior degenerates was downward from the normal moral standard, and that this notion was rightly reflected in the definitions quoted.

Dr. Edward D. Fisher said that his understanding of the term degenerate carried with it the idea of a departure from the normal standard, although there were possibly other forms of degeneracy in which the moral aspect did not enter. The term deviation seemed to him entirely inadequate.

Dr. Walton, in closing, emphasized the fact that it was intended not to displace degeneration, but to furnish a synonym which might prove useful. He saw no harm in the milder word sometimes being used to include the more severe, just as delinquent was meant to include criminal. He agreed with Dr. Sachs that deviate was too mild a word to supplant degenerate, and this was not his intention. If no objection were made to substituting deviate for superior degenerate, the ground would be practically covered. He agreed with Dr. Collins in deploring the elaboration in literature of the individual moral deviations, but this tendency could not be prevented. If we could limit our use of these terms to scientific circles, the word degenerate, as understood in those circles, would satisfy all requirements, but the subject had now become a matter of general interest.

*A Case of Cerebral Diplegia, or So-called Muscular Pseudo-hypertrophy.*—Dr. Nathan reported this case. The patient was a large, well-developed boy of ten years. On standing, there was decided lordosis. When lying down, he was apparently unable to raise himself. There was good power in the hands, and the thighs could be flexed without difficulty. He walked with the typical spastic gait. The knee reflexes and the electrical reactions to both currents were exaggerated. The mental development was nil, largely owing to neglect. The case differed from those of pseudo-hypertrophy in infantile paralysis previously reported, in several respects.

This was the only case on record, so far as known, in which pseudo-hypertrophy occurred in a case of so-called spastic spinal paralysis; all previously reported cases were hemiplegic. There were no athetoid movements in this case. The measurements showed that besides the pseudo-hypertrophy there was enlargement of the left thigh and arm.

Dr. L. P. Clark said that the condition had not been first described by him, as stated in the paper, but by Bernhard about twenty years ago. Gowers had reported a number of cases about one year later. The case reported here was evidently quite rare. Athetoid movements were noted in only about one-half of the cases, and neither this nor spasticity was sufficient to account for the cases, because this was also frequently absent.

Dr. C. L. Dana said that he did not think the diagnosis could be made solely upon the large calves, because this was frequently present in diplegics.

Dr. B. Sachs said that he quite agreed with the last speaker regarding the enlargement of the calves, and suggested that the only positive way of making the diagnosis would be by excising a piece of muscle and demonstrating the characteristic changes.

Dr. J. Collins said that if the contention were that pseudo-hypertrophic paralysis with spasticity had not been recognized, he would say that during the summer there had been in his clinic a case of typical pseudo-hypertrophic paralysis in which the spasticity was apparently as great as in the case just reported. Although there was profound spasticity, particularly of the adductors, there was no exaggeration of the knee-jerk, and no Babinski sign—in other words, there were no indications of disease of the pyramidal tracts. The case had been looked upon as a peculiar form of obesity before coming to the clinic.

Dr. Nathan said that it had not occurred to him that there was any doubt about the diagnosis. The history was typical of cerebral paralysis. The child was born asphyxiated, and had convulsions repeatedly up to the seventh year. He began to walk when three years old, and had always walked with difficulty. The only symptom of pseudo-hypertrophic paralysis was the enlargement of the calves. It was interesting to note that the left side was larger than the right.